

2495. MAINTENANCE OF EFFORT

A. LEGAL BACKGROUND AND AUTHORITY

42 CFR Part 441 - Services: Requirements and Limits Applicable to Specific Services

B. MAINTENANCE OF EFFORT FOR INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER AGE 21

1. The computation of maintenance of effort includes both State-owned and private facilities.
2. The computation of the maintenance of effort must be on a Statewide rather than facility-by-facility basis i.e., a composite of all non-Federal expenditures for inpatient services and active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children by participating facilities.
3. The average quarterly per capita non-Federal expenditures for the base year must be calculated by using the entire year's non-Federal expenditures divided by the total number of individuals in the facility during the year. The quotient is then divided by four. Where expenditures made by the State were not made on behalf of all individuals in the facility, the State's expenditures for allowable costs shall be divided by the number of persons on whose behalf expenditure was made. This "average quarterly per capita cost" is used to determine the base year costs for comparison with current costs.
4. In calculating the total of State and local expenditures i.e., "Non-Federal expenditures," Federal funds from all sources must be excluded. In addition, expenditures for vocational training and educational activities must not be included. The resulting figure is used in the computation of State maintenance of effort.
5. The average quarterly per capita non-Federal expenditures for the base year must be based on four quarters. If services were provided in less than four quarters, the base year computation must be based on the number of quarters in the base year that services were provided.

6. Per capita expenditures for the base year are based on the total number of patients in a facility, not title XIX eligibles only. Average quarterly per capita expenditures for the base year are determined by dividing the total non-Federal expenditures, as defined in 4 above, by the total number of patients in the facility (or the number for whom expenditures were made, if smaller), and then dividing the quotients by four.

The number of patients in a facility is derived as follows: assume that four individuals were patients for a full quarter, two individuals were patients for a month and a half, and three individuals were patients for a month: for that quarter, the composite number of patients is six.

<u>Patients</u>	<u>Period</u>	<u>Composite Number</u>
4 @	Quarter 4	
2 @	1/2 Quarter	1
3 @	1/3 Quarter	1
TOTAL		6

7. Facilities opened for occupancy after January 1, 1972, or which did not receive State aid during the base year are not included in the base-year calculation. Base year expenditures are only those expenditures made in the the 4-quarter period ending December 31, 1971, for services in those facilities which received State aid for patients 21 years of age and under. It is immaterial with respect to base-year calculations whether facilities opened after that year.
8. Although the specific regulatory requirements will not be applied retroactively, a State which provided inpatient psychiatric services to individuals under age 21 prior to the effective date of the regulation, April 13, 1976, will be held accountable for applying the statutory maintenance of effort provision from the year in which the service was added to the State title XIX plan.
9. The purpose of the maintenance of effort computation is to establish net State and local government expenditures for services. Accordingly, State and local government expenditures must be reduced by the amount of patient income, or relatives' contributions or third party payments applied toward the cost of care. Only the reduced (adjusted) expenditures figure is

used for calculation of State effort. For example, if cost of care billed to the State in a quarter amounted to \$100,000 and patient income or other payments of the type described above in the amount of \$5,000 were applied to cost of care, the net State expenditures would be \$95,000 (\$100,000 - \$5,000).

10. The maintenance of effort requirements for non-Federal expenditures as expressed in Section 1905 (h)(2), §441.182(a), and §441.182(a)(2), allow comparison of outpatient expenditures for the "same types" of facilities in the current quarter and the base year. The language of 1905(h)(2) speaks to "active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children." It specifies no limitations as to types of facilities, i.e., strictly outpatient or strictly inpatient-outpatient and it does not require JCAH certification. The outpatient care could have been provided either by a facility offering both inpatient and outpatient services such as a psychiatric hospital, or by an outpatient psychiatric facility such as a community mental health clinic.
11. Inpatient psychiatric hospital services must be reimbursed on a reasonable cost basis under §447.262(a). For inpatient services in other facilities such as community mental health centers and residential treatment facilities, the agency may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances. (Also, see §447.341 for upper limits applicable to individual practitioners.)
12. Any capital expenditures disallowed under section 221 of P.L. 92-603 must be excluded from the computation of State expenditures.

Section 221 of Public Law 92-603 (section 1122 of the act) provides an option for States to enter into agreements with the Secretary to assure that Federal funds are not used to support unnecessary capital expenditures. The legislation authorizes the Secretary (after consultation with various qualified planning agencies) to disallow amounts paid to providers of services for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, related to capital expenditures that are determined to be inconsistent with State or local health facility plans.

A capital expenditure which is not properly chargeable as an expense of operation and maintenance and which (1) exceeds \$100,000; (2) changes the bed capacity of the institution; or (3) substantially changes services provided by the institution. If the Secretary determines, after

consultation with the appropriate national advisory council, that disallowance of such expenditures would be inconsistent with effective organization and delivery of services or effective administration, he may allow such expenses. Participating States are required to establish procedures by which a facility or organization proposing a capital expenditure may appeal, to an agency designated by the Governor, decisions by planning agencies. The Department's basic regulations on this provision are in 42 CFR Part 100, Subpart A.

13. The following format is acceptable for submitting the maintenance of effort information:

1. Base Year (Calendar year 1971) Example

(a) Average per capita inpatient expenditures \$ 95

Divide total non-Federal expenditures for inpatient psychiatric services by the total population in the facilities during calendar year 1971. Where expenditures made by the State were not made on behalf of all individuals in the facility, the State's expenditures for costs shall be divided by the number of persons on whose behalf expenditure was made. Divide that quotient by 4.

(b) Number of inpatient eligibles in current quarter 100

Enter composite total number of individuals who receive inpatient care for the entire quarter (see question 6)

(c) Average quarterly inpatient expenditures \$ 9,500

Enter the product of (a) X (b).

(d) Average quarterly outpatient non-Federal expenditures 500

(e) Total base year average expenditures \$ 10,000

Enter the sum (c) + (d).

11. Current Quarter

(f) State and local expenditures for Medicaid eligible inpatients \$ 9,000

Enter total expenditures, net of any Federal funds received directly or indirectly by any facility (see question 4) and of any patient payments, relatives contributions, and third-party liability payments applied to the cost of such care (see question 9).

(g) Total expenditures for eligible outpatients. \$5,000

Enter total non-Federal expenditures for outpatient services to eligible individuals.

(h) Total quarterly expenditures. \$ 14,000

Enter the sum of (f) + (g).

(i) Excess of current quarter over base year costs. \$14,000

Subtract (e) from (h) and enter the difference.

III. Computation of FFP

FFP is at the 100% rate for the amount by which current expenditures, exceed base year expenditures, but may not exceed the Federal medical assistance percentage times the total inpatient expenditures for eligible individuals for the quarter.

(j) Upper limits not to be exceeded. \$ 6,300

Enter the product of State's FMAP (70%) x (f).

(k) Excess of current quarter costs over base year costs. \$ 4,000

Enter amount from (i)

(l) Amount of FFP is (j) or (k), whichever is less \$4,000 FFP

2497. DOCUMENTATION REQUIRED TO SUPPORT A CLAIM FOR FEDERAL FINANCIAL PARTICIPATION

2497.1 Statement of Policy.--Federal financial participation (FFP) is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers. Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met.

2497.2 Availability of Documentation.--Before you file a claim for FFP, you must review all documentation necessary to support the allowability of the claim. A final compilation of all supporting documentation must also be immediately available when you file a claim for FFP, i.e., complete documentation in readily reviewable form must be in your possession. This requirement is consistent with 45 CFR 74.61 subsection (b), which requires that you maintain accounting records "which identify adequately the source and application of funds for grant- or subgrant-supported activities," and subsection (g), which requires that your accounting records be supported by appropriate source documentation. This does not mean that all documentation must be in one location within the State Medicaid agency. It does mean that you must maintain and have readily available for audit, at your offices, individual case files and any other files containing the documents which you have reviewed.

2497.3 Maintenance of Documentation.--You must have a record-keeping system which assures that documentation supporting a claim is regularly maintained, easily retrieved, and in readily reviewable form. 42 CFR 431.17 requires that you "maintain or supervise the maintenance of the records necessary for the proper and efficient operation of the $\frac{1}{4}$ State $\frac{1}{2}$ plan." 42 CFR 433.32 requires that you "maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements".

2497.4 Documentation Required to Meet Two-Year Filing Limitation.--For your FFP claim to be considered timely, it must be filed and fully documented (as described above) within the two-year period following an expenditure, pursuant to § 1132 of the Act and 45 CFR 95.7. An expenditure for Medicaid services is considered made in the quarter in which you make a payment to the service provider, pursuant to 45 CFR 95.13(b). SMM § 2560.4.G.1.(a) states that, in the case of a public facility or provider, a State agency (SA) makes an expenditure when it is paid or recorded, whichever is earlier; in the case of a non-public facility or provider, an expenditure is incurred when paid by any SA.

When you file an FFP claim, it must be supported by sufficient documentation to assure that the expenditure was made on behalf of an eligible recipient for covered services rendered by a certified provider. Failure to have this documentation available in readily reviewable form at the time a claim is filed is not considered a valid reason for waiving the two-year limitation under § 1132 of the Act.

2497.5 Filing of Inadequately Documented Claims.--Claims filed within the two-year filing period that are inadequately documented when submitted are not considered filed timely based on documentation which you first reviewed or created after the date of the claim. The statutory time restrictions cannot be enforced if States are permitted to develop documentation after a claim is filed. Consequently, the Federal Government restricts its audit of claims to available documentation which you reviewed in the course of developing your claim. This includes, but is not limited to, documentation of eligibility determinations, provider certifications, and questions of covered services required by Federal statute, regulations, policy statements, and/or State law and regulations.

2497.6 Availability of Documentation Concerning Eligibility Decisions.--You are not required to make an eligibility decision prior to the delivery of service. However, you must formally determine a recipient to be eligible for Medicaid prior to your filing a claim for expenditures made on his or her behalf. The mere inclusion in an individual case record of facts sufficient to support an eligibility decision is not sufficient assurance that you knew the individual was eligible when you submitted a claim for FFP. The requirements for FFP are not met if, at the time a claim is filed, you have access to, but not possession of, records needed to make an eligibility determination.

2497.7 Allowability of Claims Based on Sampling.--Claims for FFP which use expenditures made on behalf of a sample group to estimate expenditures for a larger population within your State are unallowable. These claims are not based on documentation that fully supports the eligibility of recipients, coverage of services, and certification of providers. The use of estimates to file a claim for the same period based on extrapolation from a sample to a universe or to file a claim for a future period based on projections derived from that sample does not meet the requirements for FFP. Therefore, estimates and any other claims containing undocumented expenditures are invalid when submitted and cannot be made valid by the presentation of additional facts at a later date, absent the filing of a new claim within the statutory time limits.

(SECTION 2500 BEGINS ON PAGE 2-111.2)

2500. QUARTERLY MEDICAID STATEMENT OF EXPENDITURES FOR THE MEDICAL ASSISTANCE PROGRAM

A. Background. --The Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form HCFA-64) is the accounting statement which you, in accordance with 42 CFR 430.30(c), must submit each quarter under title XIX of the Social Security Act (the Act). It shows the disposition of Medicaid grant funds for the quarter being reported and previous fiscal years, the recoupment made or refunds received, and income earned on grant funds. You are not accountable for interest earned on grant money pending disbursement for program purposes. (See 31 U.S.C §6503(2).) However, you are accountable for the Federal share of any interest earned on recoupments or refunds pending their return to the Federal government. It is also the vehicle for making adjustments for any identified overpayment and underpayment to you.

1. Reported Expenditures. --The amounts reported on Form HCFA-64 and its attachments must be actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed. Form HCFA-64 is a statement of expenditures for which you are entitled to Federal reimbursement under title XIX and which reconciles the monetary advance made on the basis of Form HCFA-25 filed previously for the same quarter. Consequently, the amount claimed on the Form HCFA-64 is a summary of expenditures derived from source documents such as invoices, cost reports and eligibility records. All summary statements or descriptions of each claim must identify the claim and source documentation. Claims developed through the use of sampling, projections, or other estimating techniques are considered estimates and are not allowable under any circumstances. Where you are unable to develop and document a claim for expenditures on a current basis, withhold it until the actual amount, supported by final documentation, has been determined. Report that amount on a future Form HCFA-64 as a prior period adjustment.

NOTE: Inability to develop and document a claim does not waive the time limit of 2 years for submission of claims established by §1132 of the Act, nor is it a reason for allowing the claim under the "Good Cause" exception. See subsection D.

The automated Medicaid Budget and Expenditure System (MBES) has been implemented nationwide. The system allows you to electronically submit your Form HCFA-64 directly to the HCFA Data Center and the Medicaid data base. You have been trained in the use of the MBES and have been provided with the required users manual, user ID number, access codes, telephone number, and computer software necessary to access and use the system. We ask that you use it to submit your Form HCFA-64.

When using the MBES, you do not have to submit a hardcopy of the signed certification statement to HCFA. We have modified the MBES to allow you to complete the signature/certification form through the MBES and simply transmit this form to us.

When the signature/certification form appears on the screen, you simply fill in the information requested and the form is transmitted as part of the Form HCFA-64 that you are transmitting. We then accept this automated signature/certification in lieu of a separate hardcopy submission. **HOWEVER, YOU MUST KEEP AN ACTUAL SIGNED COPY OF THE SIGNATURE/CERTIFICATION FORM IN YOUR FILES FOR EACH FORM HCFA-64 YOU SUBMIT OVER THE MBES SO THAT IT IS AVAILABLE UPON REQUEST BY HCFA.** Use of this procedure results in the elimination of all hardcopy submissions to HCFA Central Office and to the Regional Offices (RO).

Once you have completed a transmission of a Form HCFA-64 and the check back is completed, call your RO and inform them that the transmission has been completed.

2. Collection of Overdue Medicare Part A Premiums. --Under §301 of the Medicare Catastrophic Coverage Act of 1988, P.L. 100-360, you may pay premiums for certain groups of needy individuals in the Medicare Hospital Insurance Program (referred to as HI or Medicare Part A). The benefit to you is to pass along certain expenses to the Medicare program which otherwise have to be paid by the Medicaid program. If you fail to pay the premiums when due, you violate the contractual agreement. In this situation, the Secretary under the authority of the Federal Claims Collection Act of 1966, codified in 31 U.S.C. 3711, and the implementing regulations located in 42 CFR 401, Subpart F, may recover the amounts due, including interest, by offset against funds owed you. The interest is calculated the same as the calculation under Part B premiums. (See §2500.6.M.)

Report the total computable amount and Federal share on Line 17.A of Form HCFA-64.9 regardless of whether the payment is made by you or offset by HCFA. In these cases, HCFA recognizes the expenditures on the grant award for that expenditure report and deducts the invoiced amount from the funds you are reimbursed. Report interest charged on overdue premiums on Line 5 of HCFA-64 Summary Sheet.

3. Nurse Aide Training Costs. --Your responsibilities for the new nurse aide training and competency evaluation programs include specifying programs which meet Federal requirements and specifying those aides who can be deemed to meet Federal requirements. In addition, nursing facility costs for the actual training and competency evaluation programs are considered State administrative costs.

Section 1903(a)(2)(B) of the Act provides for reimbursement at a 50 percent rate except for the nine quarters beginning with July 1, 1988 and ending September 30, 1990. For these nine quarters only, you are paid an enhanced rate of the Federal Medical Assistance Payment (FMAP) percentage (see §1905(b) of the Act) plus 25 percentage points not to exceed 90 percent for any additional costs you incur. Claim these expenditures on the Form HCFA-64.10 or 64.10p.

4. Federally Qualified Health Center Service (FQHC). --Section 1905(a)(2) of the Act now includes (1) outpatient hospital services, (2) rural health clinic services, and (3) Federally Qualified Health Centers. FQHC services are defined the same as the services provided by rural health clinic services, and include physician services, services provided by physician assistants, nurse practitioners, clinical psychologists, clinical social workers, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to physician's services. In certain cases, services to a homebound Medicaid patient may be provided. Any other ambulatory service included in your Medicaid plan is considered a covered FQHC service if the center offers it.

5. Drug Rebate Offset. --Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) requires that Federal matching for expenditures is denied for prescription drugs of any manufacturer that does not enter into an agreement to provide specified rebates to States on a quarterly basis. Under certain circumstances, Federal matching is available for non-rebated "breakthrough" drugs. The law allows the agreement to be entered into up to March 31, 1991 and any such agreements are deemed in effect as of January 1, 1991. States that elect to offer prescription drug coverage under their Medicaid programs are required to cover all of the drugs of any manufacturer

entering into and complying with such an agreement, with the exception of drugs (e.g., cosmetic drugs, fertility drugs, non-prescription drugs) on a statutory list (which may be revised by the Secretary). Vaccines are not subject to the rebate agreements.

You have the option of imposing prior authorization requirements for covered prescription drugs, but any prior authorization programs must provide a response within 24 hours and must ensure that patients have access to a 72-hour emergency supply of any medically indicated drug. New drugs may not be subject to prior authorization for a period of six months after FDA approval.

In CYs 1991 and 1992, the rebate for single source and innovator multiple source drugs is the greater of 12.5 percent of the Average Manufacturer Price (AMP) or the difference between AMP and the manufacturer's best price for that drug (excluding the Department of Veterans Affairs' depot and single award contract prices). In CY 1991, the maximum rebate is 25 percent of the AMP. In CY 1992, the maximum rebate is 50 percent of the AMP. In CY 1993 and thereafter, the rebate is the greater of 15 percent of AMP or the difference between the AMP and the manufacturer's best price. There is no maximum rebate and the best price is not indexed.

In addition, the rebate for single source and innovator multiple source drugs includes an adjustment for inflation, to reflect the difference between the AMP on October 1, 1990, indexed by the CPI-U, and the current AMP. Prior to 1994, the adjustment is calculated on a drug-by-drug basis. Beginning in 1994, the adjustment is calculated on an aggregate basis for each manufacturer's product line, weighted for volume in each State.

The rebate for non-innovator multiple source and over the counter drugs is 10 percent of AMP in CYs 1991 through 1993 and 11 percent of AMP thereafter.

6. Drug Claims System. --Section 4401 of OBRA 1990 provides an enhanced matching rate of 90 percent (see §1903(a)(3)(A)(i) of the Act) for CYs 1991 and 1992 for State acquisition of electronic point of sale claims management system, for the purpose of performing on-line, real time eligibility verifications, claims data capture, adjudication of claims, and assisting pharmacists (and other authorized persons) in applying for and receiving payment.

7. Drug Use Review Program. --Section 4401 of OBRA 1990 requires that the States establish a drug use review program by January 1, 1993. It provides for 75 percent funding during CYs 1991 through 1993 for the amounts expended that are attributable to Statewide adoption of a drug use review program.

8. Drug Implementation Costs. --Section 4401 of OBRA 1990 allows for a temporary increase in the Federal matching rate for administrative costs to 75 percent during calendar quarters in FY 1991 (i.e., October 1, 1990 through September 30, 1991) for the costs attributable to the administrative activities necessary to carry out all of the drug implementation except the drug review program. The Federal matching rate reverts back to 50 percent after September 30, 1991.

9. Group Health Plan Payments. --Section 4402 of OBRA 1990 requires States to purchase employer group health insurance for Medicaid beneficiaries, when cost effective to do so, starting January 1, 1991. In general, cost effective means that the reduction in Medicaid expenditures for a recipient enrolled in a group health plan is likely to be greater than the additional expenditures for premiums and cost sharing required under this section. Beneficiaries are not required to pay any more for services than if they were receiving only Medicaid, and you are required to furnish wrap-around coverage

to ensure that beneficiaries have the full scope of Medicaid benefits.

10. Home and Community-Based Care for the Functionally Disabled Elderly. -- Section 4711 of OBRA 1990 provides for home and community based services for functionally disabled elderly. The expenditures for this optional service are capped at \$580 million over five years. A State that elects this option must provide services to all eligibles in the State without regard to whether there are sufficient Federal funds available to fund services for a full four quarters. The Secretary establishes State specific Federal funding limitations accounting for State demographics in relation to national demographics. This provision is effective July 1, 1991.

11. Community Supported Living Arrangement. -- Section 4712 of OBRA 1990 establishes an option within the Medicaid program allowing States to provide community supported living arrangement services to individuals with mental retardation or a related condition who are otherwise eligible for Medicaid. Benefits are limited to individuals living in their own or family's home, apartment or other rental units in which no more than three individuals receiving these services reside. Federal matching payments are capped at \$100 million over five years and are provided to two to eight States, selected by the Secretary. This optional services also contain a maintenance of effort requirement.

B. Submission of Form HCFA-64. -- In order that the Secretary may determine that funds advanced to you for the operation of the Medicaid program have been accounted for properly, report your quarterly expenditures on Form HCFA-64 within 30 days after the end of each calendar quarter. (See 42 CFR 430.30(c).) It constitutes your claim for Federal reimbursement.

C. Revisions to Form HCFA-64. -- If you later determine that an expenditure report submitted for a given quarter did not contain all expenditures for that quarter, include the additional expenditures on the next Form HCFA-64 report as a prior period adjustment.

You may submit an advance expenditure report to meet the timely filing deadline. Request assistance from your RO regarding when to file it.

D. Reporting Requirements. --

1. Medicaid Funding Limitations Policy. -- The HCFA policy on funding limitations is covered under §2560. (See Pub. L. 96-272, 45 CFR Part 95, Time Limits for States to File Claims, and §1132 of the Act.) HCFA pays the Federal share of allowable claims filed within the following time frames:

a. Pre-FY 1980 Expenditures. -- Expenditures made prior to October 1, 1979 must have been filed by May 15, 1981, unless they meet one of the exceptions in subsection c.(1)-(4).

b. FY 1980 and Later Expenditures. -- Expenditures made on or after October 1, 1979 must be filed within 2 years after the calendar quarter in which you made the expenditure unless they meet one of the following exceptions. (The following is the Medicaid interpretation of exceptions defined in 45 CFR Part 95).

c. Exceptions. --

(1) "Adjustments to prior year costs" include only public providers and adjustments to expenditures made based upon an interim rate. The rate is subject to final cost settlement provided that it is claimed within 2 years after the quarter in which it was made.

(2) "Audit exceptions" include only adjustments to public providers for expenditures previously claimed under the Medicaid program made as the result of an independent audit finding. The audit finding must have been adopted by the DHHS OIG, Office of Audit or been an audit finding by the GAO which is determined by HCFA to be allowable.

(3) "Court ordered retroactive payment" means either a retroactive payment you made to an assistance recipient or individual under a Federal or State court order, or a retroactive payment HCFA makes to you under a Federal court order. Although HCFA may accept these claims as timely, it may not agree to be bound by a State or Federal court decision when not a party to the action.

(4) "Good Cause" exception claims are those you filed late due to circumstances beyond your control, where the Secretary determines that good cause existed. Report these claims on Form HCFA-64 expenditure report as prior period claims, with the Secretary's waiver referenced.

2. FMAP Rate Applicable to Expenditures/Recoveries. --When reporting expenditures for Federal reimbursement, apply the FMAP rate in effect at the time the expenditure was recorded in your accounting system. An expenditure occurs when a cash payment is made to a provider. Noncash expenditures, such as depreciation, are made when they are recorded in the accounting records in accordance with generally accepted accounting principles. The term State means any agency of the State including the State Medicaid agency, its fiscal agents, a State health agency, or any other State or local organization incurring matchable expenditures.

Section 1903(a)(1) of the Act provides that HCFA reimburse you quarterly an amount equal to the FMAP of the total amount expended during such quarter as Medical Assistance under the approved State plan. It provides that HCFA reimburse you at the FMAP rate for the quarter in which the expenditure was made, even if the expenditure is not claimed for Federal reimbursement until some later quarter. To establish the FMAP rate applicable to a given expenditure, determine when the expenditure was made.

When the expenditure cannot be tied to a specific prior period, compute the Federal share at the current FMAP rate. Make adjustments to reflect the correct FMAP rate in subsequent HCFA-64 forms as adjustments to prior period claims. Do not delay the refunding of the Federal share simply because you cannot immediately tie the expenditure to a specific prior period.

E. Citations. -- Citations contained in these instructions are to the Code of Federal Regulations (CFR).

F. Forms Transmittal. --If you do not submit your Form HCFA-64 using MBES, send the original and two copies of Form HCFA-64 and supporting schedules to:

Health Care Financing Administration
Budget and Grants Branch, DFM, OMM, MB
Room 281 East High Rise
P.O. Box 26678
Baltimore, MD 21207-0278

Send the appropriate RO one copy. We have instituted an automated and consolidated budget and expenditure data base for the Medicaid Program to be input by a single data entry system at the point of origin. When you implement this method, you do not need to send any forms, but keep a copy of the certification page.

Direct inquiries concerning the Form HCFA-64 to your RO financial management contact. Copies of the Form HCFA-64 may be obtained from the Budget and Grants Branch, at the above address, or by calling (301) 966-2005.

2500.1 Preparation of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Summary Sheet and Certification, Form HCFA-64. --

A. General. --Prepare a Form HCFA-64 Summary Sheet for the Statement of Expenditures for Medical Assistance and State and Local Administration for MAP.

Lines are provided in Section A to report interest received on Medicaid recoveries, interest assessed on disallowances, and Medicare overpayment recovered through reductions in Medicaid payments to the affected providers. These actions do not affect State and Federal expenditures.

Amounts reported in Columns (a) and (b) on Line 6 are supported by Form HCFA-64.9. Amounts reported in Columns (a) and (b) on Line 7, 8, 10.A or 10.B are supported by Form HCFA-64.9p. (See §2500.2.)

Amounts reported in Columns (a) and (b) on Line 9.A are supported by Form HCFA-64.9a. (See §2500.3.)

Amounts reported in Columns (a) and (b) on Line 10.C are supported by Form HCFA-64.9o. (See §2500.4.)

Amounts reported in Columns (c) and (d) on Line 6 are supported by Form HCFA-64.10. Amounts reported in Columns (c) and (d) on Lines 7, 8, 10.A or 10.B are supported by Form HCFA-64.10p. (See §2500.5.)

B. Detailed Instructions. --Complete the heading sections of the report by entering the name of the State, title of the SA, and the ending date of the quarter reported.

Column (a) - TOTAL COMPUTABLE. --Enter the total computable amount of MAP for the Program.

Column (b) - FEDERAL SHARE. --Enter the Federal share of MAP for the Program.

Column (c) - TOTAL COMPUTABLE. --Enter the total computable amount of the State and Local Administration Expenditures (ADM) for the Program.

Column (d) - FEDERAL SHARE. --Enter the Federal share of ADM for the Program.

Section A - Quarterly Status Of Funding

Line 1 - Awards Received During The Quarter For The Quarter Being Reported And Prior Quarters. --Enter the Federal share of awards received for the program which were dated (award letter) within the quarter reported and were for the current or a prior quarter.

Line 2 - Awards Received During The Quarter For Subsequent Quarter. --Enter the Federal share of awards received for the program which were dated (award letter) within the quarter reported but are for a subsequent period.

Line 3 - Interest

Line 3.A - Received On Medicaid Recoveries. --Enter the Federal share of any interest received or earned on Medicaid recoveries during the quarter.

Line 3.B - Assessed On Disallowances. --Enter any interest on disallowances assessed by HCFA under §1903(d)(5) and 42 CFR 433.38 during the quarter reported. Report the total amount of interest as shown on the grant awards

received during the quarter.

Line 4 - Medicare Overpayment Collections Under §1914 and 42 CFR 447.30. --Enter the collections for overpayments made to Medicare providers who are also Medicaid providers. If more than one such recoupment was made during the quarter, attach a schedule showing the amount and identification number for each.

Line 5 -- Use this line to report interest charged on the offset collection of overdue Medicare Part A or Part B premiums. Enter "Interest-Overdue Premiums Part A/B" as appropriate on the blank Line 5 to identify the amount.

NOTE: Under the automated system, you are not able to enter on the blank lines.

Section B -- Expenditures Reported For Period

Line 6 - Expenditures In This Quarter. -- Accompany each Summary Sheet Form HCFA-64 by one base Form HCFA-64.9 and/or Form HCFA-64.10. Where additional HCFA-64.9 or 64.10 forms are prepared to report such items as waiver expenditures or other current quarter expenditures, the base Form HCFA-64.9 or 64.10 includes the expenditures they reported. Amounts shown on the additional forms are for informational reporting purposes and to support amounts contained in the base Forms HCFA-64.9 and 64.10 figures. Enter the totals on the base Forms HCFA-64.9 and HCFA-64.10 and the grand totals on the Form HCFA-64 Summary Sheet.

Enter in Column (a) the amount from Line 25, Column (a) of Form HCFA-64.9.

Enter in Column (b) the amount from Line 25, Column (f) of Form HCFA-64.9.

Enter in Column (c) the amount from Line 14, Column (a) of Form HCFA-64.10.

Enter in Column (d) the amount from Line 14, Column (f) of Form HCFA-64.10.

NOTE: Enter the total computable amount and Federal share of decreasing adjustments for recoveries, collections, cancelled checks, and overpayment on Line 9.D of Form HCFA-64, Summary Sheet. Do not net these adjustments in Line 6.

Line 7 - Adjustments Increasing Claims For Prior Quarters. -- Enter the total computable amount and Federal share of adjustments increasing claims for expenditures in prior periods, and attach Form HCFA-64.9p (Medical Assistance Payments) and/or Form HCFA-64.10p (State and Local Administration). Where more than one form is used, enter on the Summary Sheet the sum of all amounts shown on the referenced lines on each.

Enter in Column (a) the amount(s) from Line 25, Column (a) of the HCFA-64.9p form(s).

Enter in Column (b) the amount(s) from Line 25, Column (f) of the HCFA-64.9p form(s).

Enter in Column (c) the amount(s) from Line 14, Column (a) of the HCFA-64.10p form(s).

Enter in Column (d) the amount(s) from Line 14, Column (f) of the HCFA-64.10p form(s).

NOTE: Expenditures reported on Line 7 include only increasing adjustments made to private or public providers in prior quarters which were not

reported on a prior Form HCFA-64. Report cost settlement and other increasing adjustments to private providers made in the current quarter for an earlier period on Line 6 as a current expenditure. (See §2560, Medicaid Funding Limitations Policy.)

Line 8 - Other Expenditures. --Enter the amounts, other than those reported on Lines 6 and 7, as an adjustment to Federal funds. Examples include increasing audit adjustments, FMAP rate changes, and corrections of amounts previously reported.

Where expenditures have been claimed at an inappropriate reimbursement rate, deduct the original claim on Line 10.B and reclaim it on Line 8 using the revised rate. For example, if you had claimed MMIS expenditures at the 50 percent FFP rate and you later determine that the expenditures should have been claimed at the 75 percent FFP rate, deduct the expenditures at the 50 percent FFP rate on Line 10.B. Reclaim the expenditures at the 75 percent FFP rate on Line 8.

Accompany any amount shown on Line 8 of the HCFA-64 Summary Sheet by a Form HCFA-64.9p (Medical Assistance Payments) and/or Form HCFA-64.10p (State and Local Administration).

Enter the amounts on Line 8 from the Form HCFA-64.9p and/or HCFA-64.10p in the same manner as for Line 7.

Line 9 - Collections. --Enter all collections received during the quarter. Amounts reported on Lines 9.A - 9.E need not be accompanied by a Form HCFA-64.9p or Form HCFA-64.10p.

Compute the Federal share of amounts reported at the Federal matching rate at which HCFA matched your original expenditure.

Do not report collections of overpayment which occurred before October 1, 1985 and have been reported on Line 10.B, or overpayment which occurred on or after October 1, 1985 and have been reported on Line 10.C.

Support Line 9.A of the Form HCFA-64 Summary Sheet by Form HCFA-64.9a.

For entries on Line 9.B, 9.C, or 9.D, make available documentation supporting the collections upon request.

Line 9.A - Third Party Liability (TPL) Collections. --Report only collections made during the quarter for TPL on Line 9.A of the Summary Sheet. Report their source on Form HCFA-64.9a, Schedule of Third Party Liability Collections.

Enter in Column (a) the amount from Section A-Third Party Liability Collections Line 2, Column (a) of the Form HCFA-64.9a.

Enter in Column (b) the amount from Section A-Third Party Liability Collections Line 2, Column (b) of the Form HCFA-64.9a.

Line 9.B - Probate Collections. --Enter the amounts collected from the estates of deceased title XIX recipients. Many Medicaid recipients, particularly the aged in long-term care facilities, die without survivors. You can take part in benefit recovery through a probate collection.

Line 9.C - Collections Identified Through Fraud And Abuse Effort. --Comply with 42 CFR Parts 440, 441, 442 and 447 regarding the availability of FFP in valid covered services and 42 CFR Part 455 regarding fraud in the MAP. Many cases of suspected Medicaid fraud or abuse developed through program integrity

efforts are referred to the State agency for appropriate action rather than to State or Federal prosecution authorities.

Collections may be made by the Federal government as part of Civil Monetary Penalty (CMP) actions. Where a CMP action is taken, and the provider returns an overpayment to the Federal government, the State share is returned by a U.S. Treasury check. In these instances, recognize the return of the overpayment by reporting a Line 9.C adjustment. Since the Federal government obtains the Federal share of the overpayment, HCFA does not recognize the decreasing adjustment for Federal funding purposes. (See §2500.6.A.)

Collections may be made by the State or local entity as part of CMP actions. Where a CMP action is taken and the State collects the Federal and State share, recognize the return of the overpayment by reporting a Line 9.C adjustment. Include a footnote identifying the CMP collection. Note the total computable amount and the Federal share. Since the Federal government has not obtained the Federal share of the overpayment, HCFA includes the adjustment in the grant award computation.

Enter on Line 9.C the total computable amount in Column (a) and the Federal share in Column (b) of the Medical Assistance expenditures identified in a fraud and abuse effort case(s) and recovered as an overpayment.

Overpayments in this context are total Medicaid funds a provider has received in excess of amounts due and payable under the statute and regulations, as identified through review and examination by the fraud and abuse component of the State agency, the special fraud unit, where certified, or the Office of Investigations (OI) of OIG.

Line 9.D - Other Collections. --Enter the total computable amount in Column (a) and the Federal share in Column (b) of all collections other than TPL, probate and overpayment identified through fraud and abuse effort recoveries. Enter refunds, cancellations, and amounts collected by the imposition of a lien under §1917 of the Act and 42 CFR 433.36.

NOTE: Report on Line 9.D, Columns (c) and (d) the total computable and Federal share of all collections related to State and Local Administration for the MAP.

Line 9.E - Reserved.

Line 10 - Adjustments Decreasing Claims For Prior Quarters.

Line 10.A - Federal Audit (specify DHHS common identification number). --Enter the Medicaid amounts identified by Federal audits as reported on an accompanying Form HCFA-64.9p and/or HCFA-64.10p.

Line 10.B - Other (Specify). --Enter all decreasing adjustments for prior periods except for audit disallowances reported on Line 10.A and overpayments reported on Line 10.C. With respect to claims previously filed and disallowed by HCFA, make the Line 10.B adjustment on the next expenditure report after a disallowance has been issued and you have not appealed, or a disallowance has been upheld by the DHHS Grant Appeals Board. Report all overpayments which occurred before October 1, 1985 and which have not been refunded to HCFA.

Line 10.C - Overpayment Adjustments. --Report the total computable amount and Federal share of all overpayment that must be refunded because the 60-day period following discovery has expired and you have not made recovery.

Enter the total computable amount reported on Line 5, Column (a) of the Form

HCFA-64.9o in Column (a) on Line 10.C of the Form HCFA-64 Summary Sheet.

Enter the Federal share amount reported on Line 5, Column (f) of the Form HCFA-64.9o in Column (b) on Line 10.C of the Form HCFA-64 Summary Sheet.

NOTE: Report overpayments which occurred before October 1, 1985, and for which you have not made recovery on Line 10.B of the Form HCFA-64 Summary Sheet. Report overpayments which occurred before October 1, 1985 for which you have made recovery as collections on Line 9.C or 9.D, as appropriate.

The Federal share of overpayments occurring on or after October 1, 1985 must be refunded no later than the quarter in which the 60-day period following discovery ends, whether or not you have made recovery. If you do recover the overpayment before the end of the 60-day period following discovery, report the collection on Line 9.C or 9.D, whichever is appropriate. Report overpayments not recovered on Line 1 of the Form HCFA-64.9o. Enter Line 5 from Form HCFA-64.9o on Line 10.C of the Form HCFA-64 Summary Sheet to reflect these adjustments. If the Federal share of an overpayment which occurred on or after October 1, 1985 has previously been returned as a Line 10.C adjustment, do not report subsequent collection of that overpayment.

NOTE: Report decreasing adjustments to overpayments which occurred before October 1, 1985 that were reported on Line 10.B on Line 8 of the Form HCFA-64 Summary Sheet.

Report increasing adjustments to overpayments which occurred before October 1, 1985 on Line 10.B.

See §§2500.6.A, 2500.6.C and 2853 for further discussion of Medicaid overpayment recovery policy.

Line 11 - Net Expenditures Reported In This Period. -- Enter the sum of Lines 6, 7, and 8, Lines 9.A to 9.E, and 10.A to 10.C.

C. Preparation of the Statement of Certification for Medical Assistance Payments. -- Complete the heading sections of the report by entering the name of the State, title of the SA, and the ending date of the quarter reported.

HCFA-64 Summary Sheet Submitted (Date)

Enter the date the expenditure report was transmitted to the CO through MBES. Otherwise, enter the date the same as the date signed.

Column (a) - TOTAL COMPUTABLE. -- Enter the total computable amount of MAP for the Program.

Column (b) - FEDERAL SHARE. -- Enter the Federal share of MAP for the Program.

Column (c) - TOTAL COMPUTABLE. -- Enter the total computable amount of the State and Local Administration Expenditures (ADM) for the Program.

Column (d) - FEDERAL SHARE. -- Enter the Federal share of ADM for the Program.

Net Expenditures Reported on Line 11

Enter in column (a) the amount from Line 11, column (a) of Form HCFA-64 Summary Sheet.

Enter in column (b) the amount from Line 11, column (b) of Form HCFA-64 Summary Sheet.

Enter in column (c) the amount from Line 11, column (c) of Form HCFA-64 Summary Sheet.

Enter in column (d) the amount from Line 11, column (d) of Form HCFA-64 Summary Sheet.

Sign and date the certification using MBES. This certification also applies to the supporting schedules. The Executive Officer of the State/Jurisdiction agency or the designated representative signs the certification. Keep a copy of the signed report in your file.

If you do not use MBES, forward the signed original and two (2) copies within 30 days after the end of each quarter to HCFA at the address in §2500.F. Forward a copy to the RO. Attach the supporting computation forms and schedules to the original and each copy of the Summary Sheet.

THIS PAGE RESERVED FOR "QUARTERLY MEDICAID STATEMENT OF
EXPENDITURES FOR THE MEDICAL ASSISTANCE PROGRAM"

(CERTIFICATION CHART)

THIS PAGE RESERVED FOR "QUARTERLY MEDICAID STATEMENT
OF EXPENDITURES FOR THE MEDICAL ASSISTANCE PROGRAM"
SUMMARY SHEET
SECTIONS A AND B